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THE RIGHT TO BE WRONG

Sex and Gender Decisions

1. INTRODUCTION

A series of events occurred within a very short period and prompted consideration of the ethical dimensions of how, when, and why individuals, institutions or governments decide to get involved in people's lives. In particular we began to question if they should get involved with allowing, or not allowing, people to make major decisions regarding their own bodies. This is an essay reflecting such thoughts. It involves consideration of two tenets of medical practice: *Relieve pain and suffering;* and *First, do no harm.*

In order of occurrence, the events started when we were considering a legal case involving a 13-year-old female.[1] Alex, as the judge sitting on the case called her, had successfully argued in an Australian court that, in accordance with her wishes, she could live as a male and obtain the necessary medical help to achieve this. This means Alex, from that time on, would be getting hormones to prevent typical female puberty and at the age of sixteen years will receive androgenic hormones to virilize bodily and facial features. At the age of eighteen Alex will be eligible to obtain a hysterectomy and ovariectomy to stop any menses and feminization, and eventually to have a phallus constructed if he so wishes. The appropriate legal and professional psychological and medical experts, consulted prior to the decision, have made these recommendations. Religious and other factions, however, immediately challenged the decision. They complained Alex was too young to make such a choice, that the procedures would lead to later regret, and most crucially, would end Alex's ability to have children. [2]

The second instance involved a legal suit brought against a gender clinic by someone who had surgically and socially transitioned from living as a male to living as a female. Alan Finch, at the age of twenty-one had applied to the clinic for help with a desire for sex reassignment surgery (SRS). Therapists at the clinic vetted Mr. Jones's situation and approved of the transition. Surgeons subsequently removed his penis and testicles and in their stead fashioned a vulva and vagina. After living as a woman for eight years Mr. Finch decided it had been a mistake and now feels he should never have been allowed to transition and he ought to live as a man.[3] Mr. Finch blames the psychiatrists who counselled him and is suing the clinic at which they worked. Although he admits to having lied to the therapists during his meetings

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with them, he claims they should have realized he was conflicted over his gender. The clinic is protesting the suit saying, on the one hand, that the therapists involved had followed established procedures, and in any case, this had all occurred prior to the expiration of the statute of limitations. According to records, indeed, the clinic professionals did adhere to professionally approved procedures.[4] The local government is presently conducting a clinical review of the complaint and relevant occurrences.[5] In the meanwhile, factions both supporting and ridiculing the original transition, the secondary one, and the claim against the clinic have come forward. [6]

The third case involved a tragedy. David Reimer, while still an infant had his gender changed. A botched circumcision to repair phimosis of his penis resulted in its destruction. His parents were advised that life as a male without a penis would be intolerable and that he should be raised as a girl. They were told that he would then develop satisfactorily as a female (Diamond and Sigmundson, 1997; Colapinto 2000). This did not happen. David consistently objected to his life as a girl and repeatedly asked to live as the boy he felt to be. His life became so miserable that, at the age of 14, without knowing of his history, he threatened suicide unless he could live as a male. While he subsequently grew to live and marry as a man at the age of 25, he continued to have flashbacks to his early troubled life so that he eventually committed suicide at the age of thirty-eight.[7]

The practice of sex reassignment in similar cases when a penis has been lost due to infant trauma or accident, or when it is considered unusually small, is still current. It also occurs in many cases of intersexuality without the child's consent.[8] The correctness of this practice is a subject of current professional and lay debate. Some physicians still hold to its justification; while others, particularly those individuals who feel they were ill-served by such treatment, object (Diamond, 2004). We say more of this below. David's story is better known as the case of John/Joan and received wide coverage from many media.[9]

The fourth case is more mundane and also more common. A married father of two wrote to one of us (MD) seeking advice. For this discussion we call him Phil Johnson. At his age of 42 Phil said that he was finally seriously thinking of transitioning to live as a woman. Although having thought for years about transitioning, he felt he had come to a junction in his life where he had to make a decision. However, he was conflicted. On the one hand, Mr. Johnson feared that by transitioning he would lose his wife and children, and on the other, he felt driven to follow a life long compulsion. Whether he stays with his family and sacrifices his gender desires or denies his family aspirations involves a decision with both positive and negative consequences. But Phil felt at a choice-point and a decision had to be made. Under certain jurisdictions those who transition, if married, are obligated to divorce. In other cases, those who transition cannot later marry someone of the sex from which they changed. Not only does Phil's conundrum involve legal repercussions, but also similar cases have become part of the "same-sex marriage" argument with positions strongly held by those for and against the legality of transsexual change and subsequent marriage.[10]

In the first two cases the gender shift was at the request of the individual involved and in the third it was imposed from without. The fourth case is yet to be resolved. The types of transitions involved are not unique. Over the last several

decades such cases have become the fodder of tabloids, television chat shows, documentaries and more. The Internet has become home to scores of communities that offer space for questioning, ventilation, counseling, and discussion on all sides of the relevant issues. In all of the cases, and others like them, outside individuals and groups have felt called upon to voice their opinions as to the right or wrong of these actions and choices. Some even want governmental agencies to regulate such conduct.

Three of the foregoing four cases involved individuals usually called *transsexuals*. They were said to be suffering from a condition medically called Gender Identity Dysphoria (GID) or Gender Identity Disorder. In brief, gender identity disorder is defined as the strong and persistent disturbing belief for at least two years that one is actually a member of the opposite sex (Frances et al., 1995). In David Reimer's case, he too wanted to change his gender, but it was to regain something taken away from him. While not usually identified as such, it might be said that he had an imposed disturbance of gender identity.

A basic question arises for all of these cases. Who should or should not have a right to dictate, or even have a say, in how one lives and what a person may do with his or her own body?[11] Should the voices of individuals, religious groups, political factions, or even families have determining weight in other people's decisions of such personal bodily alteration?

Those who protest against the requests often feel they are acting in the best interests not only of the individuals concerned, but also of society in general. Considering cases such as Alex's, it is plausible that a minor might change his or her mindset with increasing age and maturity. There is also logic in believing that adults, like Alan Finch or Phil Johnson, who have lived a life in one gender might regret leaving it to live in another. And experience has shown that physicians and other trained professionals usually have knowledge that should be taken into account when making life-altering decisions. There is certainly reason to accept that one might grieve over loss of genitals, facility, or opportunity. Further, it is probable that the full repercussions of any particular action might not be known or ever be known. But is it really likely that the individual involved has not considered most of the relevant matters brought up by others? Is it truly logical to believe these criticisms and objections, as well as others that might be more salient to the person involved, have not been thought of and examined?

From the point of view of the individuals concerned, there surely are important factors to consider. In Alex's case, aside from the public clamor, there is scientific evidence to complicate matters. Minors who desire sex/gender change frequently change their minds as they get to adulthood. It is also true that a majority of those considering a gender reassignment as minors, when adult manifest as persons demonstrating homosexuality without the gender dysphoria (Green, 1987; Zucker, 2004). Thus, for the adolescent, even allowing reversible treatment and permitting the adolescent to present in the opposite sex has future consequences if it solidifies a gender presentation that might have otherwise been later abandoned.

Alan Finch's situation is unusual since most transsexuals following surgery express satisfaction and delight at the outcome (Smith, et al., 2005). Only a minority experiences regret. This case is further clouded by not knowing what induced Mr.

Finch to originally desire a sex change so deeply that he would lie to the therapists regarding his life situation and motivation.

In Phil Johnson's case there are obvious family aspects of any decision that will affect others as well. Phil presents with pro and con issues of his own that must be resolved. His situation is not rare.

The original treatment for David Reimer was predicated on several points of faulty logic. The first was a belief that individuals are psychosexually neutral at birth and will adapt to any gender in which they are reared. The second was that any individual without a penis should be raised as a girl. From the start of his imposed transition, David objected to his treatment. The continued imposition of his management against his desires might even be considered child abuse. Nevertheless, the thinking that led to David's management is still used in dealing with many cases of intersexuality where ambiguous genitalia or a micropenis is present, or when genitalia are missing, as in cloacal exstrophy (Reiner, 2004).

In addition to any personal reason that might be involved, a justification offered by those that refer to the need for society's involvement in these personal decisions arises from the fear that certain actions provide a negative role model for others, or might serve as a precedent and challenge to a basic tenet held dear. They think this is reason enough to impose legal regulations on what individuals can and cannot do. Many social, governmental, and religious institutions, for example, are threatened if people make unique and atypical gender choices even if as minor as dressing in the clothes of the opposite sex. Other factions are disturbed if they or those they represent are not involved in decision making. For instance, psychotherapists or physicians might object if those among their number are not consulted regarding any gender transition. However, the role modelling has effect only on those persons who are themselves considering options regarding a possible transition. In that regard, we see it as any other educational source. We also do not believe that such actions are attractive enough to the average "onlooker" that they will be taken as behaviors to be emulated.

Some among the criticizing public base their objections on religious grounds. They quote biblical verse claiming the body is a holy temple[12] or they contend that man is made in God's image.[13] Some also think that procreation is a religious obligation and that a voluntary surrendering of reproductive ability is sinful. For many reasons individuals of different religious persuasions think the body should not be altered.

Regardless of the source of criticism, the heart of the issue is, should final decisions on instances such as the ones presented be left to government, agencies, factions, physicians, psychologists, priests, counsellors, or any other than the person particularly involved? We think not.

Certainly we think that parents or family can have a say and openly express their opinions. Yes, we think any and all groups might be consulted if that is the wish of the individual. Yes, we think interested groups should be free to offer advice and suggestions for alternate solutions to the situations faced by those like Alex, Alan, David, or Phil. And we think it is prudent to postpone the enactment of any of the actions associated with similar cases until a suitable interval of time has passed between the decision and desired action. We also think it proper that organizations

such as the Harry Benjamin International Gender Dysphoria Association (HBIGDA) establish guidelines for the transition process for transsexuals, and respective medical associations have standards for specific medical procedures.[14]

To the extent that physicians or other professionals can predict that an individual or a population is at risk for later regret, they have an ethical obligation to identify that risk and counsel the patient appropriately. For example, studies of women undergoing tubal sterilization reveal that approximately 14% will have some degree of regret in later years. The age at which sterilization occurs strongly correlates with the likelihood and degree of later regret: young women are significantly more likely to regret the decision (Schmidt et al., 2000). Yet no one would suggest that medical or other professionals should deny all younger women the choice to be sterilized because they are more vulnerable to later regret. Instead, this finding warrants extra emphasis on pre-surgery counseling for younger individuals.

We believe the ultimate decision to proceed or not should be left to the competent and mentally mature individual involved regardless of whether doing so is in keeping with the desires or advice of the public, any specified institution, or involved professionals. In terms of making decisions regarding one's own body, we believe every individual has a right to be self-determining; every one has a right to even be wrong.

Our thinking in all these cases is that rational individuals ought have authority to make even life-altering choices when it involves their bodies, regardless of public acceptance or rejection. This holds as long as these persons are then ready to live by any consequences and not hold others liable for that determination. As enunciated by philosophers such as John Stuart Mill we consider these actions as a basic tenet of individual freedom.

Mill, in his essay entitled *On Liberty* expressed it thus:

> "The sole end for which mankind is warranted, individually or collectively in interfering with the liberty of action of any of their number, is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will is to prevent harm to others. *His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinions of others, to do so would be wise, or even right."* (Emphasis ours.)[15]

Our discussion now turns to an opposite extreme regarding bodily integrity—a discussion of intersexed persons and how they are often treated. Intersexed individuals are persons with apparent anatomical admixtures of male and female biological characteristics. Such persons are not rare. Estimates of their frequency in the population vary. A conservative approximation is that an intersexed child occurs in about one per two thousand people and is recognized at birth by genitals considered ambiguously male or female (Blackless et al., 2000).[16] Since the 1950's and 1960s early surgical intervention for such individuals often was imposed. Predicated on the misguided belief that such genitals provoked a medical emergency, intersexed infants were subjected to surgery to "normalize" their genital

appearance. These surgeries were frequently done without the parents being notified of the reasoning for the operations.

In most cases the surgery involved sex-reassigning the infant from male to female since fabrication of female appearing genitals was easier than structuring male genitals. Such surgeries were also imposed when a male infant's penis had been severely mutilated by trauma (as in David Reimer's situation) or was considered significantly small (Beh and Diamond, 2000). These procedures were often instigated without informed consent of the parents in the belief that withholding information about the ambiguities and sex reassignment would foster a more satisfactory upbringing for the child. It was thought that if the parents didn't know, they would not prejudice the infant's upbringing. These practices, while less frequent, still occur.

When parents were informed of the prospect of surgery and sex reassignment they were often told that the "normal" looking genitalia would dictate the child's gender development, and that any innate gender propensity would be changed by upbringing. Despite a lack of confirming evidence, medical literature from the 1970s to the late 1990s had promoted this treatment. Supporting evidence is still scant and there is a great deal of evidence against the belief (Diamond, 1999). Much depends upon the particular intersex condition being considered.

A significant number of intersexed persons were raised in their sex-reassigned gender and then, on their own, either switched to their opposite or instead elected to see themselves, not as male or female, but as intersexed.[17] Many of the intersexed infants that had surgery, even if staying within their assigned gender, have come to criticize such treatment. Many of the original surgeries had to be redone and many surgeries reduced the erotic sensitivity of the genitals.[18] Why, these intersexed individuals ask, couldn't they be allowed to live as they were born? Many question what right the surgeons had, with or without permission of their parents, to decide to subject them to surgery? Groups of intersexed individuals, such as those of the Intersex Society of North America (ISNA), A Kindred Spirit, and Bodies Like Ours have formed and voiced objection to such treatments.

Arguments supporting reconstruction of the genitals are based on the beliefs that humans are psychosexually neutral at birth and that they fare better in life if their gender and genitals match. Reconstruction of the genitals and sex reassignment is, therefore, justified. Little evidence has been offered to substantiate that claim, however. In contrast, neurological and biological studies support the premise that humans are, in keeping with their mammalian heritage, primarily predisposed and biased to interact with environmental, familial, and social forces in either a male or female mode.[19] Further, there is no evidence from medical or other records that intersexed individuals with ambiguous genitalia faired poorly if no surgery was imposed.

Physicians further justify their surgeries on the premises that growing up with ambiguous genitalia would lead to uncertainty on the part of the child as to its gender, and that the ambiguous genitalia would elicit unflattering and derogatorily shaming comments from others. There is only untested theory bolstering the belief about gender development, and only anecdote about the occurrence and effect of unflattering and shaming comments.

There are major ethical problems with "normalizing" ambiguous genitalia without informed consent of the individual involved. The most significant is that doing so ignores the possibility that the child, when an adult, might have a different concept of what is "normal" and what is desirable. And collusion in the surgery by well-meaning parents does not rectify the situation. Indeed, it might make it worse if the mature child comes to wonder why he or she could not be loved as they were born. There are many cases where those who had such surgery as infants later rue the procedures and the thinking that went with it. In cases of infant intersexuality, we think the most ethical stance is to hold open the infant's surgical future when any proposed change is not medically, but only cosmetically, at issue. At a later date, the child can then elect or decline any appropriate surgery (Beh and Diamond, 2000).

We thus present two sides of an issue: where those who wish to change their bodies meet with social criticism and where those who involuntarily had their bodies modified criticize the social forces that led to their unwelcome surgery. In both types of situations, the critics claim they are looking out for the best interests of the individuals involved, the public good, or both. When a decision is in keeping with social norms, the populace and most professional groups generally approve and consent is tacit. When an individual's choice is unpopular, however, it causes consternation and unease. Evidence for this is not difficult to come by. Cosmetic or psychiatric surgery obtained by minors is not uncommon in the United States in instances other than transsexual considerations. According to the American Society of Plastic Surgeons the number of cosmetic surgeries performed on people under the age of 18 exceeded 74,000 in 2003, a 14 percent increase from 2000. In 2003 some 3,700 breast-augmentation surgeries were performed on teenage girls and almost as many teenage boys had their breasts reduced.[20] All that was generally needed to obtain these operations was the financial ability to pay and the consent of parents or guardians. For those that wanted to go contrary to the usual in terms of gender, however, roadblocks of all sorts existed. Males and females, thus, are denied surgery if it is associated with a desire to change their sex, but not if it is to enhance gender stereotypes. And surgery toward "normalization" is promulgated when genitalia are believed to be unusual and differ from the norm.

We accept that those who chose might be making a mistake they will later regret. Yes, there might be repercussions difficult to remedy. But mistakes happen even when actions are made following the best of intentions. Regrets are not only for taking the road less travelled, but for taking the highway as well. And there are honest differences of opinion as to those persons who make the right decision and those who make wrong. Who is to say?

In discussion of this matter we can even call upon a concept of freedom in its broadest sense and immortalized in our country's central documents. The constitution starts off with our ancestor's desire to "secure the Blessings of Liberty to ourselves and our Posterity" and the Declaration of Independence declares: "We hold these truths to be self-evident: that all men are created equal; that they are endowed by their Creator with certain unalienable rights; that among these are life, liberty, and the pursuit of happiness."

If liberty is to mean anything it must offer freedom from external restraint or compulsion. A person's liberty must be seen as a condition of legal non-restraint of

natural powers.[21] And as liberty is an inalienable right it cannot be surrendered or transferred.[22]

We thus think it is unethical to make bodily modification of adult or mature minors difficult or illegal when it is desired, and we think it equally unethical to impose, encourage, and promote it in infants when it has not been proven justified and when many on whom it has been imposed criticize the practice even to the point of claiming that it is harmful. People have a right to modify their bodies when they so choose and not have it modified without their expressed informed consent.

A parallel issue needs be considered in this discussion since the individual is not a completely independent agent. The transsexual who wants surgery, or the intersexed individual who doesn't, must interact with different professionals, usually psychotherapists and physicians.

While we presume informed patients with decisional capacity have the right to make medical treatment choices that may bother or offend the larger society, we must also acknowledge the professional's right and obligation to act within his or her conscience in cooperating with those choices. Professional obligations can serve as a legitimate limitation on patient autonomy. Nevertheless, we feel that patient autonomy should be paramount even, or perhaps especially, when exercising choice, which may result in later regret. Yet, patients do not and cannot make medical treatment decisions alone, because medical treatment, by its nature requires the participation of others who are obliged to follow their own conscience and are bound by rules of professional conduct. Thus, informed consent from competent patients may not alone suffice. Professional medical ethics, and the ethical codes of other helping professionals, preclude providing treatments for which there is no indication and those that offer no possible benefit.[23] Patients are not entitled to treatments "simply because they demand them" and physicians or others "are not ethically obligated to deliver care that, in their best professional judgment, will not have a reasonable chance of benefiting their patients."[24]

Admittedly, in some cases it might be difficult for transsexuals who desire counseling, hormones, or surgery, to everywhere find professionals willing and able to provide these services. However, there is no shortage of qualified specialists who are willing to serve. How to keep the intersexed individual from imposed surgery, however, is more problematic. Having a knowledgeable and understanding pediatrician is a place to start.

In summary, we think it is appropriate to call upon long held professional guidelines for those in the helping professions. In the first set of instances we offer "*Relieve pain and suffering*." The psychic pain and suffering of those diagnosed as transsexuals is well documented. The advice for the second set of instances, where individuals have not themselves requested surgery, is to refrain: "*First, do no harm.*" The obligation for these decisions ultimately remains with the individual, and yes, every person has a right to be wrong.

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NOTES

[1] In any discussion of transsexuality and intersex there is a sensitive issue of how nouns and pronouns are used. Most persons with a transsexual condition identify themselves unequivocally as members of the sex in which they aspire to live. Thus, Alex identifies as a male. And to Alex, sex and gender are equivalent so that male means boy or man. To most medical personnel and scientists, however, sex and gender are separate (Diamond 2002) so that a female can live and identify as a boy or man and a male can live and identify as a girl or woman. Part of the issue is how an individual's sex is determined. Over the years various indicators of sex have been emphasized (Dreger 1998); the most commonly emphasized have been chromosomes, gonads, hormonal titers, internal genitalia, external genital appearance, and social lifestyle. As knowledge and sophistication increase, however, more factors can influence the determination; a final determination of a person's "sex" might involve different gene constellations as well as brain sex. Traditionally the primary sex characteristic has been the gonads. It is now understood that an individual's gonads or related characteristics frequently do not correspond with other features of self and that variations are common. Such discrepancies and variations arise in conditions of transsexuality and intersex (and transsexuality can be considered a form of intersexuality) (Diamond, 2002). These discrepancies and variations have implications over and above any grammatical matter. A resolution of the conflicting methods for assaying sex would have legal and practical relevance. It would address the problem that arises when a person is considered a male in one state, a female in another, and an intersexed person in a third. Persons with an intersexed or transsexual condition consider, not their gonads, but their brains, their core sense of self, as the primary determinant of sex. Presently this is best evaluated by the individual's own admission rather than by any scientifically objective measure. In this paper we use the terms as they are most generally understood. In general, however, persons of any category should be addressed and regarded as they see themselves. See also Wallbank (2004).

[2] "Re Alex: Hormonal Treatment for Gender Identity Dysphoria." FLR 180.89 (2004). Available at <http://www.austlii.edu.au/au/cases/cth/family_ct/2004/297.html> See also Beh & Diamond, "Ethical Concerns."

[3] Patrick Goodenough. "'Sex-Change' Clinic Faces Inquiry, Lawsuit." Cnsnews.com: May 05, 2004. Available at <http://www.cnsnews.com/ForeignBureaus/Archive/200405/FOR20040505a.html>; "Double Sex-Change Patient to Sue." Fairfax Digital: 2004. Available at <http://www.smh.com.au/articles/2004/09/15/1094927634658.html?from=storylhs&oneclick=true#>; "Alan Finch-Man to Sue Over Sex Change." ABC NewsOnLine. Available at http://www.gendertrust.org.uk/news162.php.

[4] Standardized procedures for the treatment of GID have been established by the Harry Benjamin International Gender Dysphoria Association. Available at http://www.hbigda.org/soc.cfm.

[5] Op. Cit. Goodenough 'Sex-Change." Last Update: Friday, November 12, 2004. 5:49pm (AEDT).

[6] Greg Ansley. "Alan Finch-Caught in the Wrong Body." *New Zealand Herald*. (2004). Available at http://www.gendertrust.org.uk/news157.php.

[7] Black, Debra. "Sex, Lies and a Quest for Identity." *Toronto Star*. (May 11, 2004, A3).

[8] Beh, H. G. and M. Diamond (2000); Kipnis, K. and M. Diamond (1998).

[9] Colapinto, J. "The Boy Who Was Turned into a Girl." *BBC Horizon Productions*: Dec. 6. 2000; "Sex Unknown." *PBS NOVA*: 30 October 2001 (*WGBH Productions*).

[10] *Littleton v Prange* (Texas case) at <http://www.pfc.org.uk/legal/littletn.htm>; Wilgoren, Jodi. "Suit Over Estate Claims a Widow Is Not a Woman." *New York Times*. (January 13, 2002).

[11] We are not extending this discussion to include issues such as prostitution, drug use or other practices that involve one's voluntary exposure of the body to risk. Those topics involve public policies that already have histories of extensive debate. This current discussion is limited to issues of body modification.

[12] 1 Corinthians 6:19-20.

[13] Genesis 1:26-27.

[14] HBIGDA is a professional organization devoted to research and overview of the clinical management of transsexualism.

[15] Mill, J. S. (1909).

[16] A more liberal consideration of the frequency of individuals in the population with intersex conditions gives a figure exceeding one percent (Fausto-Sterling, 2000).

[17] Diamond, Milton (2004); Diamond, M. and L. A. Watson (2004); Beh, H. G. and M. Diamond (2000); Schober, J. M. (2001).

[18] Creighton, Sarah M., C. L. Minto, et al. (2001); Kuhnle, U., M. Bullinger, et al. (1995).

[19] Diamond, Milton (1995); Diamond, M. and L. A. Watson (2004); Hamer, D. and P. Copeland (1998). Wilson, B. E. and W. G. Reiner (1998).

[20] Mary Duenwald. "The Consumer; How Young Is Too Young to have a Nose Job and Breast Implants?" *N.Y. Times*. (Sept. 28, 2004 at F5). Available at <http://www.nytimes.com/2004/09/28/health/28cons>

[21] Gove, P. B. *Webster's Third New International Dictionary of the English Language, Unabridged*. Springfield, Mass: G. & C. Merriam Company, 1971.

[22] "At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life." *Lawrence v. Texas* 213 S. Ct., 2472, 2481 (2003).

[23] AMA Code of Medical Ethics, Opinions on Practice Matters E-8.20.

[24] AMA Code of Medical Ethics, Opinions on Social Policy Issues E-2.035.

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